State of Louisiana

Department of Health and Hospitals
Office of Aging and Adult Services

DESIGNATION OF RESPONSIBLE REPRESENTATIVE

Requestor/Applicant/Participant Name:	**DOB:**

I understand that the role(s) of the responsible representative(s) are to accompany, assist, and represent me in the Home and Community Based Services assessment, care planning, and service delivery processes. The responsible representative should assist in gathering all necessary information for these processes. I understand that I do not have to name anyone as a responsible representative. If I do name someone, I understand that I still have the right and the responsibility to actively take part in my assessment, care plan, and service delivery.

I understand this may require the Department of Health and Hospitals (DHH) to give information to the representative(s) named below that may otherwise be personal and confidential. I hereby waive my rights to prevent sharing of information by DHH with the responsible representative(s) named below. I hereby allow DHH to share with my responsible representative(s) only the information necessary for him/her to perform the functions described above.

I understand that I am naming only the individual(s) named below, and that they remain my representative until DHH or its contractors receive a written statement or form from me saying that this person is no longer my representative. I understand that the person(s) I name as my responsible representative(s) may not be my paid direct service worker(s). I understand that the person(s) I name as my responsible representative(s) may not serve as the responsible representative(s) for more than two individuals receiving Medicaid Home and Community-Based Services operated by the Office of Aging and Adult Services.

I understand that while some of the information gathered may have no impact on assessment, care plan and service provision processes, it may affect my liability to a third party should this information be disclosed to the third party by my responsible representative(s). I hereby hold harmless and agree to indemnify DHH from any claim resulting from disclosure of information to a third party by my responsible representative(s).

Responsible Representative Name:	
Relationship to Requestor/Applicant/Participant:	
Address:	
Home Phone #:	**Other Phone(s) #:**

2nd Responsible Representative Name:	
Relationship to Requestor/Applicant/Participant:	
Address:	
Home Phone #:	**Other Phone(s) #:**

Applicant/Participant's Signature:	**Date:**
Witness' Signature:	**Date:**